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Date Issued: August 30, 2000

Case No: 1999-BLA-1207

In the Matter of

TERRY M. FIFE,
Claimant

v.

YOGI MINING COMPANY, INCORPORATED,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Ron Carson, Lay Representative
For the claimant

Russell Presley, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (hereinafter "the Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis,

commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (1996).

On August 5, 1999, this case was referred to the Office of Administrative Law Judges for a formal hearing. Following proper notice to all parties, a hearing was held on April 12, 2000 in Abingdon, Virginia. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had an opportunity to submit additional evidence and to present closing arguments or post-hearing briefs. A brief on behalf of the claimant was received on June 19, 2000. A brief on behalf of the employer was received on June 23, 2000.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the claim was timely filed;

2. the length of the miner's coal mine employment;

4. whether the miner has pneumoconiosis as defined by the Act and regulations;

5. whether the miner's pneumoconiosis arose out of coal mine employment;

6. whether the miner is totally disabled;

7. whether the miner's disability is due to pneumoconiosis;

8. the number of the miner's dependents for purposes of augmentation of benefits; and

9. whether the named employer is the responsible operator.

(DX 32).

The employer also contests other issues that are identified at line 18 on the list of issues. (DX 32). These issues are beyond the authority of an administrative law judge and are preserved for appeal.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Terry Fife, was born on December 27, 1956. (DX 1). The miner attended school through the ninth grade. Mr. Fife married Patricia Joyce Stump on September 27, 1980, and they reside together. (DX 1, 9). On his application for benefits, the claimant alleged that he has one dependent child, Rajni Patel Fife. (DX 1).

On his application for benefits, Mr. Fife stated he is "unable to breathe freely at any time." *Id.* He further stated his shortness of breath has rendered him "unable to perform short or long term tasks." *Id.* The claimant stated "dust in the mines and in and around other jobs" has made it harder for him to try to breathe. *Id.* During the April 12, 2000 hearing, the claimant testified he had smoked approximately one package of cigarettes per day since 1975 and was still smoking a that rate. This smoking history does not vary significantly from the smoking histories he reported to the physicians of record. On February 12, 1999, Mr. Fife reported a smoking history to Dr. J. Randolph Forehand of one package of cigarettes per day since 1979. (DX 14). The miner reported the same smoking history to Dr. Abdul Dahhan on July 28, 1999. (EX 2).

Mr. Fife filed his application for black lung benefits on December 17, 1998. (DX 1). The Office of Workers' Compensation Programs issued an Initial Finding of Entitlement on May 10, 1999. (DX 24). Yogi Mining Company, Incorporated (hereinafter "Yogi Mining") requested a formal hearing before an administrative law judge on July 9, 1999. (DX 27). Pursuant to the employer's request for a formal hearing, the case was transferred to the Office of Administrative Law Judges on August 5, 1999. (DX 32). A formal hearing was held before me in Abingdon, Virginia on April 12, 2000.

Timeliness

Under Section 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. At the formal hearing, Mr. Fife testified that although he left the coal mines in May 1993, a physician did not inform him that he was totally disabled by pneumoconiosis until February 1999. (Tr. 28).

Because the record contains no evidence that claimant received the requisite notice more than three years prior to filing his claim for benefits, I find that Mr. Fife's claim was timely filed.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). On his application for benefits, Mr. Fife alleged eighteen years of coal mine employment. The evidence in the record includes a Social Security Statement of Earnings encompassing the years 1972 to 1998, an employment history form, an application for benefits, affidavits from records custodians, and the claimant's testimony. (DX 1,2,3, 4, 5, 6, 7).

The Act fails to provide specific guidelines for computing the length of a miner's coal mine work. However, the Benefits Review Board consistently has held that a reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 BLR 1-67, 1-72 (1996) (en banc); *Dawson v. Old Ben Coal Co.*, 11 BLR 1-58, 1-60 (1988); *Niccoli v. Director, OWCP*, 6 BLR 1-910, 1-912 (1984). Thus, a finding concerning the length of coal mine employment may be based on many different factors, and one particular type of evidence need not be credited over another type of evidence. *Calfee v. Director, OWCP*, 8 BLR 1-7, 1-9 (1985).

A July 26, 1999 affidavit of Pamela Sturgis, the Human Resources Secretary for Clinchfield Coal Corporation (hereinafter "Clinchfield Coal"), indicates Mr. Fife was employed by Clinchfield Coal from January 25, 1975 to June 23, 1977 and from June 5, 1978 to August 6, 1979. (DX 34). Employment with Clinchfield Coal from October 1975 to January 1977 is further corroborated by pay stubs the miner has submitted into the record. (DX 5). Mr. Fife testified he worked as a utility man and a mine helper while employed by Clinchfield Coal. (Tr. 18). Therefore, I credit the claimant with three years and seven months of qualifying coal mine employment with Clinchfield Coal.

Mr. Fife had additional earnings from coal mine employment from 1977 to 1979. The claimant's social security records indicate he earned approximately $6598 from Mabo Coal Company (hereinafter "Mabo Coal") during 1977 and $4327.75 during 1978, and $240.00 from Betty Lynn Coal Company, Incorporated during 1979. (DX 7). By comparing the claimant's wages for subsequent years with the wages he earned from Mabo Coal and Betty Lynn Coal, I credit the claimant with an additional six months of coal mine employment with Mabo Coal during 1977 and additional three months of coal mine employment during 1978. During 1980, the claimant received a total of approximately $8469 in coal mine employment wages from Dominion Coal Corporation, Patrick Coal Corporation, Top Notch Coal Company, Incorporated, and W & L Coal Company. By comparing

the miner's 1980 coal mine employment wages with his wages for subsequent years, I find that earnings of $8469 during 1980 reflect approximately six months of coal mine employment during 1980. Therefore, I credit Mr. Fife with six months of coal mine employment during 1980. Mr. Fife also received $22, 365.19 in wages from Patrick Coal Corporation during 1981. I find such wages reflect one full year of coal mine employment with Patrick Coal Corporation and credit the claimant with the same.

Mr. Fife earned the following wages from Yogi Mining: $17, 141.20 during 1982; $10,802.97 during 1983; $16,307.88 during 1984; $16, 264.00 during 1985; $16, 418.83 during 1986; $10, 081.96 during 1987; $20, 818.67 during 1988; $23, 397.80 during 1989; $19, 272.25 during 1990; $15, 942.50 during 1991; $16, 326.25 during 1992; and $9,052.50 up to May 1993. Based on Mr. Fife's employment with Yogi Mining Company, I credit him with eleven years and five months of qualifying coal mine employment from 1982 until May 1993. Accordingly, I credit the miner with a total of seventeen years and three months of qualifying coal mine employment.

Mr. Fife was last employed by Yogi Mining as a roof bolter. (Tr. 22). The claimant left the coal mines on May 13, 1993 when he was laid off from his job at Yogi Mining. *Id.* Mr. Fife testified he left the mines not only because the mine in which he was working shut down, but also because of his breathing problems. *Id.* at 23. The claimant stated he cannot return to his job at Yogi Mining as a roof bolter because "he could not breathe enough to keep up if [he] had to go back and because he "could not handle the dust." *Id.* at 25. Mr. Fife testified all of his coal mine employment was underground and involved very dusty conditions. *Id.* at 21-22.

Dependency

An award of benefits under the Act can be augmented on behalf of a miner's spouse and children, provided such individuals meet the conditions set forth in the regulations. Counsel for the employer stipulated that Mrs. Fife, the claimant's wife, is a dependent of the claimant for purposes of benefit augmentation. (Tr. 14). Thus, the only remaining dependency issue is whether any benefits awarded to the claimant may be augmented on behalf of the claimant's son, Rajni Patel Fife. Thus, I must evaluate the evidence of record to determine whether Rajni Fife is the child of the claimant within the meaning of Section 725.208 and whether Rajni Fife is dependent upon the claimant within the meaning of Section 725.209.

A Certificate of Live Birth from the Commonwealth of Virginia indicates Rajni Patel Fife was born to Patricia and Terry Fife on August 14, 1979. (DX 10). Therefore, I find Terry and Rajni Fife have a parent-child relationship as contemplated in Section 728.208. Section 725.209 provides a child of a miner will be deemed dependent on the miner if the child is unmarried and either under eighteen years of age, or is over eighteen years of age and either a student or under a disability as defined in Section 233(d) of the Social Security Act, 42 U.S.C. 423(d). At the time Mr. Fife filed his application for benefits, Rajni Fife was over eighteen years of age. However, a Notice of Reconsideration from the

Social Security Administration indicates Rajni Fife was found to be disabled and awarded Supplemental Security Income benefits on June 4, 1998. (DX 11). Because Rajni Fife was found disabled by the Social Security Administration at the age of nineteen, I find he suffers from a disability as defined in section 223(d) of the Social Security Act. Furthermore, because Rajni Fife is unmarried and suffers from a disability as the term is defined in section 233(d) of the Social Security Act, I find the child is dependent upon the claimant within the meaning of Section 725.209. Accordingly, any benefits awarded to Mr. Fife should be augmented on behalf of his disabled son as well as his spouse.

Responsible Operator

In order to be deemed the responsible operator for this claim, Yogi Mining must have been the last employer in the coal mining industry for which Mr. Fife had his most recent period of coal mine employment of at least one year, including one day after December 31, 1969. 20 C.F.R. §§ 725.492(a), 493(a). The Social Security records and the claimant's employment history forms establish that Yogi Mining Company, Incorporated was the last employer to meet these conditions. (DX 2, 7). Therefore, I find that Yogi Mining Company, Incorporated properly is designated as the responsible operator for Mr. Fife's claim.

State Workers' Compensation Award

Mr. Fife apparently received a State Workers' Compensation award from the State of Virginia based on pneumoconiosis or some other chronic lung disease. (DX 8). A Request for State Workers' Compensation Information completed by a claim's examiner from the Virginia Workers' Compensation Commission indicates payments were made to the miner beginning November 17, 1986. The amount of any benefits awarded to the claimant under the Act may need to be offset by the amount of the State Workers' Compensation award.

Medical Evidence

A. X-ray Reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Film Qlty.	Interpretation
DX 28	8/27/98	7/2/99	Scott/BCR, B[1]	3	No pleural or parenchymal abnormalities consistent with pneumoconiosis; bilateral upper lung infiltrates compatible with tuberculosis
DX 28	8/27/98	7/3/99	Wheeler/BCR, B	3	No pleural or parenchymal abnormalities consistent with pneumoconiosis; moderate course fibrosis or ill-defined infiltrates in posterior subapical portion upper lobes and involving pleura compatible with tuberculosis, unknown activity; elevation hila and few tiny calcified granulomata in infiltrates and right pleura indicate at least some healing; hyperinflation lungs probably from emphysema
DX 16	2/12/99	2/12/99	Forehand/B	2	1/1, size B large opacities
DX 18	2/12/99	3/1/99	Sargent/BCR, B	3	1/1; designates size A large opacities but states he is “un-certain” about whether the x-ray revealed early large opacities, tuberculosis or granulomatous disease
DX 30	2/12/99	7/13/99	Scott/BCR, B	2	0/1; nodular infiltrates and scarring apices with hilar

[1]When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board and the Sixth Circuit Court of Appeals have approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Warmus v. Pittsburgh & Midway Coal Mining Co.* 839 F.2d 257, 261, n.4 (6th Cir. 1988); *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984). A "B" reader (abbreviated as “B” above) is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology (abbreviated as “BCR” above) may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

					elevation; changes compatible with tuberculosis, partially healed; associated apical pleural thickening also typical for tuberculosis
Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Qlty.	Film Interpretation
DX 30	2/12/99	7/13/99	Wheeler/BCR, B	2	0/1; coarse and focal infiltrates or fibrosis upper lobes and lower apices compatible with tuberculosis unknown activity with volume loss right upper lobe and elevation minor fissure and hilum favoring healed tuberculosis and fibrosis; small nodular infiltrate in mid and upper lungs with probable few small calcified granulomata and minimal bilateral pleural fibrosis near scapulae compatible with tuberculosis; pneumoconiosis is unlikely because pattern is coarse, involves pleura and lower apices; probable minimal emphysema with few areas of decreased and distorted lung markings in mid and upper lungs; it would be unusual for a man this young to have advanced pneumoconiosis without overwhelming unprotected dust exposure and this is most likely untreated tuberculosis, hopefully self-secured
EX 2	7/28/99	7/28/99	Dahhan/B	*	1/1, r, r, size A large opacities

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Qlty.	Film Interpretation
EX 1	7/28/99	8/10/99	Scott/BCR, B	1	No pleural or parenchymal abnormalities consistent with pneumoconiosis; nodular infiltrates both upper lungs with associated pleural thickening compatible with tuberculosis, unknown activity, hilar elevation bilaterally, di; no background of small rounded opacities to suggest that the masses could be rounded opacities of pneumoconiosis; a few scattered blebs and bullae are present in the lungs
EX 1	7/28/99	8/11/99	Wheeler/BCR, B	1	0/1, t, r; moderate coarse and nodular infiltrates or fibrosis in upper lobes and lower apices extending to lateral pleura with probable few small calcified granulomata compatible with tuberculosis, activity unknown; at least partly healed 3 - 4 centimeter mass in subapical portion both upper lobes compatible with conglomerate tuberculosis and minimal pleural fibrosis on both lateral chest walls near scapulae; probable emphysema with few small bullous blebs in upper lobes; silicosis and coal workers' pneumoconiosis could account for some nodules in this case but tuberculosis best explains

all findings, including subapical predominance and pleural and apical involvement

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Qlty.	Film Interpretation
CX 2	12/21/99	*	Alexander/BCR, B	2	2/2, r, q, category B complicated pneumoconiosis, ax, di, em, bilateral chest wall pleural thickening
EX 8	12/21/99	4/21/00	Scott/BCR, B	2	0/1; bilateral apical infiltrates/fibrosis probably due to tuberculosis, unknown activity; bilateral 3.5 - 4 centimeter masses probably granulomatous due to tuberculosis; thickened adjacent pleura; cannot rule out minimal silicosis/coal workers' pneumoconiosis
EX 8	12/21/99	4/21/00	Wheeler/BCR, B	2	0/1; tuberculosis unknown activity with roughly 4 centimeter mass or fibrosis in subapical portion upper lobes and lower apices compatible with conglomerate tuberculosis and mixed linear and nodular infiltrates and probable few small calcified granulomata in upper lobes with lateral pleural fibrosis near scapulae and minimal elevation right hilum indicating at least some healing; suggest computer tomography scan for better evaluation and to see if masses are calcified; probable emphysema with areas of decreased and distorted lung markings; masses in upper lobes are unlikely to

be large opacities because there is apical and pleural disease and he is quite young; most large opacities are from unprotected drillers from World War II

B. Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 FVC	Tracings	Comments
DX 12 2/12/99	Forehand	42/65"	2.78	3.86	84	72%	Yes	Good effort; expiratory volumes and flows are normal; inspiratory and expiratory flow volume curves are not indicative of upper airway obstruction; normal ventilatory pattern
EX 2 7/28/99	Dahhan	42/66.2"	1.81	2.45	36	73.9%	Yes	Fair cooperation and good comprehension; Mr. Fife refused bronchodilator, stated he was allergic to a lot of medi- cine and he was afraid to take it

C. Arterial Blood Gas Studies

EXHIBIT/ DATE	PHYSICIAN	TEST RESULTS pCO_2	pO_2	Resting/ Exercise	Comments
DX 15	Forehand				Claimant fainted during

2/12/99					insertion of the arterial catheter and was unable to undergo resting or exercise arterial blood gas studies

EXHIBIT/ DATE	PHYSICIAN	TEST RESULTS pCO_2	pO_2	Resting/ Exercise	Comments
EX 2 7/28/99	Dahhan				Resting blood gases were attempted, however, patient became very pale, sweaty, and disoriented and then lost consciousness and was "out" several minutes; after patient layed down a few minutes, he did state that he wanted to continue with the exam, but requested no blood be drawn

D. Narrative Medical Opinions

Dr. J. Randolph Forehand examined Mr. Fife on February 12, 1999. (DX 14). In a report prepared on the date of the examination, Dr. Forehand noted the claimant has an eighteen year coal mine employment history and had been smoking one package of cigarettes daily since 1979. Dr. Forehand's examination included an x-ray of the miner's chest, a pulmonary function study, and an electrocardiogram. An arterial blood gas study was not performed because the claimant fainted during insertion of the arterial catheter. Dr. Forehand diagnosed Mr. Fife with complicated coal workers' pneumoconiosis. The physician also stated the claimant should have a tuberculin skin test to rule out tuberculosis as an additional diagnosis. Dr. Forehand further stated Mr. Fife's chest x-ray is "indicative of a significant lung injury." The physician opined the miner "is not able to return to his last coal mining job" and is totally and permanently disabled. The physician stated "complicated pneumoconiosis is the sole factor contributing to" Mr. Fife's pulmonary disability. Dr. Forehand is certified by the American Boards of Pediatrics and Allergy & Immunology. (DX 17).

Dr. Abdul Dahhan, a physician who is board-certified in internal medicine and pulmonary medicine, examined Mr. Fife on July 28, 1999. (EX 2). In a July 30, 1999 examination report, Dr. Dahhan recorded an eighteen year coal mine employment history and a smoking history of one package of cigarettes per day since 1979. Dr. Dahhan's examination included an electrocardiogram, an x-ray of the miner's chest, and a pulmonary function study. According to Dr. Dahhan, "arterial blood gases were attempted [during the examination, but the claimant] had a severe vasovagal reaction with a fainting-like sensation associated with bradycardia, pallor and sweating." Thus, the physician stated the test was terminated and no exercise study was done. Dr. Dahhan opined the claimant's spirometry was invalid because the miner exhibited a poor effort. Dr. Dahhan also reviewed interpretations of a July 28, 1999 chest x-ray by Drs. Wheeler and Scott and computer tomography scan readings by each of those physicians. Dr. Dahhan
found no evidence of occupational pneumoconiosis. The physician reasoned a clinical examination of the miner's chest revealed obstructive abnormalities and the miner's lung volumes and diffusion capacity were normal. Dr. Dahhan acknowledged the miner's chest x-ray was "abnormal," but he attributed the abnormality to granulomatous disease rather than coal dust exposure or pneumoconiosis. Dr. Dahhan also indicated he based his opinion as to the existence of pneumoconiosis on the miner's x-ray and computer tomography scan interpretations. The physician opined the claimant has a "history consistent with chronic bronchitis." Dr. Dahhan stated exact measurements of the claimant's respiratory function were not possible because the miner exhibited a poor effort during the spirometry testing. Nevertheless, the physician thought Mr. Fife "appear[ed] to have no evidence of total or pulmonary disability" because the miner's lung volumes and diffusion capacity were normal and because a clinical examination of the miner's chest revealed mild obstructive abnormalities.

On March 27, 2000, Dr. Dahhan reviewed additional medical of record and rendered a consultative opinion. (EX 7). Based on the computer tomography scan readings and x-ray interpretations of Drs. Wheeler and Scott, Dr. Dahhan concluded insufficient evidence existed to justify a diagnosis of coal workers' pneumoconiosis. The physician opined that none of the objective evidence indicated the miner suffers from a pulmonary impairment or disability. He based his opinion on the spirometry performed at Dr. Forehand's office and the lung volumes and diffusion capacity measurements taken during his July 1999 examination of the claimant. Dr. Dahhan opined Mr. Fife retains the respiratory capacity to perform his previous coal mining job or a job of comparable physical demand.

Counsel for the employer deposed Dr. Dahhan on April 6, 2000 in Harlan, Kentucky. *Id.* Dr. Dahhan testified that he does not believe the claimant suffers from coal workers' pneumoconiosis. The physician stated that during his examination of the claimant, the claimant "described a history of daily cough with sputum production, history of wheeze, and shortness of breath," but explained such complaints are found in various medical conditions and are not diagnostic of a specific cardiopulmonary or pulmonary condition. The physician testified a clinical examination of Mr. Fife's chest revealed "abnormal findings" consistent with obstructive airway disease, such as the miner's thorax was larger than it should have been, there was an increased amount of air as demonstrated by hyper resonancy to

percussion, and a few expiratory wheezes were heard upon exhalation. The physician testified that he classified the miner's chest x-ray as revealing category 1/1 opacities and a "large shadow" he thought "could be consistent with a size A large opacity." Nevertheless, Dr. Dahhan stated he later concluded the claimant does not suffer from complicated pneumoconiosis because a computer tomography scan of the miner's chest, interpreted by an individual who Dr. Dahhan thought was experienced in radiology, was not indicative of a large opacity. When asked to explain the abnormalities noted on the miner's chest x-ray, Dr. Dahhan testified they were "probably due to old granumlomatous disease, most likely tuberculosis." The physician stated such conditions are conditions of the general public and are attributable to infections caused by bacteria which heal and scar the lungs. Dr. Dahhan stated spirometry was performed during the examination; however, he opined the results of the spirometry were invalid. Specifically, he stated Mr. Fife's effort and cooperation "were not sufficient to produce a valid study." The physician stated two static tests of the miner's lung function were performed even though the mechanics of the miner's respiratory system in the dynamic phase could not be measured. Arterial blood gas studies were not conducted because the claimant had a severe vasovagal reaction when the arterial stick was attempted. Thus, Dr. Dahhan was unable to offer an opinion as to whether Mr. Fife suffers from a blood gas exchange abnormality. According to Dr. Dahhan, Mr. Fife's lung volume measurements were normal because the miner's residual volume and functional residual capacity were normal. A diffusion capacity test, which Dr. Dahhan testified measures the permeability of the lining of the lung, was also performed. According to the physician, the test was normal and thus indicated "no impairment in the diffusion of the respiratory system." Based on the diffusing capacity test and the lung volume test, Dr. Dahhan stated he could only testify that "the miner is able to move air in and
out of his lungs very well, and.. [that] the lining of the miner's lung is intact and available for exchange of air and blood." He stated the pulmonary function study performed at Dr. Forehand's request, when considered in connection with the normal diffusing capacity Dr. Dahhan found during his examination of the claimant, led him to conclude Mr. Fife has a sufficient respiratory capacity to perform his last coal mining employment. Dr. Dahhan stated that in reaching such a conclusion, he considered the fact that the claimant's last coal mining job involved sustained heavy labor. The physician opined the miner suffers from no pulmonary impairment or disability related to coal dust exposure.

Dr. J.P. Sutherland, Jr., the claimant's treating physician since 1992, submitted a letter dated February 9, 2000 in which he discusses the claimant's pulmonary condition. (CX 1). The physician stated Mr. Fife has had "recurrent problems of dyspnea and shortness of breath associated with severe wheezing even on mild exertion." Dr. Sutherland stated one of the miner's chest x–rays revealed "interstitial scar tissue in all five lung fields with hyperation [sic] with obstructive and restrictive lung disease." The physician stated the miner's occupational dust exposure is the cause of the diagnosed restrictive and obstructive lung disease. Dr. Sutherland opined the miner is "totally and permanently disabled because of restrictive and obstructive lung disease associated with pneumoconiosis." The physician opined Mr. Fife is not able to return to the coal mining industry. According to Dr. Sutherland, Mr. Fife "has no evidence of any type of gohn lesions with granulomatous disease except for interstitial changes which would be consistent with pneumoconiosis." The physician stated he reviewed "films

from Dr. Scott" which agreed with his findings "associated with nodular infiltrate and scarring in both hilar regions."

In his letter, Dr. Sutherland noted the claimant worked in the coal mines for approximately eighteen years. In an effort to alleviate Mr. Fife's "severe dyspnea," the physician has pres-cribed various bronchodilators, corticosteriods, and has had the miner try various pulmonary strengthening exercises. Dr. Sutherland noted previous chest x-rays interpreted by various physicians are indicative of significant lung disease and injury. According to Dr. Sutherland, the claimant was evaluated for tuberculosis and coccidial mycosis, but no evidence of either disease was found. The physician reiterated that based on the miner's x-ray findings and physical examination findings, he believes the miner suffers from "significant, irreversible lung disease" caused by his exposure of "multiple years in and around coal dust."

Dr. Peter Tuteur reviewed the medical evidence of record and rendered a consultative opinion on October 5, 1999. (EX 4). In his report, Dr. Tuteur noted the claimant has an eighteen year coal mine employment history and had been smoking cigarettes at the rate of one package per day since 1979. Dr. Tuteur also noted the claimant has no history of being diagnosed with tuberculosis. When reviewing the pulmonary function studies of record, Dr. Tuteur stated:

> The study of July 28, 1999 is associated with lesser numerical values but is invalid as an assessment of maximum function because of a lack of reproducibility. Though the "total capacity" was reported as 4.4 liters, true total lung function capacity was not measured. The reported measurement was a single breath nitrogen washout required as part of the diffusing capacity which regularly underestimates true total lung capacity and just reflects alveolar volume. When coal workers' pneumoconiosis is sufficiently advanced to produce impairment of pulmonary function, one expects to find not an obstruction, but a restrictive ventilatory defect. In this case the normal FEV of 3.9 liter on June 12, 1999 indicates the absence of such a restrictive ventilatory defect. Furthermore, impairment of gas exchange may develop. Here, at least at rest, the SpO2 was well within normal limits. The subsequently performed invalid study does not negate these normal pulmonary function studies. When coal workers' pneumoconiosis is sufficiently advanced to produce impairment of pulmonary function, one expects to find either a restrictive ventilatory defect manifested by a reduced total lung capacity, or if not appropriately reduced forced vital capacity. This is not the case here. In addition, one may expect impairment of gas exchange. The resting SpO2 of 99% indicates normal gas exchange at rest.

Dr. Tuteur opined Mr. Fife does not suffer from a clinically or physiologically significant coal workers' pneumoconiosis. The physician stated "the consensus, based on both standard chest radiographs and a computer tomography scan of the thorax suggest the absence of coal workers' pneumoconiosis and the presence of the tissue reaction in response to an infection."

Dr. Tuteur further explained the miner does not have the clinical symptoms, abnormal physical examination findings, or impairment of pulmonary function associated with pneumoconiosis. Dr. Tuteur opined the miner's history of breathlessness, cough expectoration, wheezing, chest discomfort associated with an intermittently abnormal chest examination and a normal set of pulmonary functions represent the consequences of cigarette-smoke induced early chronic obstructive pulmonary disease. Dr. Tuteur also attributed the "emphysematous changes seen on the computer tomography scan and suspected on standard radiographs" to a cigarette-smoke induced condition. Thus, Dr. Tuteur opined the claimant does not suffer from coal workers' pneumoconiosis or an impairment in pulmonary function. The physician opined the claimant
has the pulmonary capacity to perform coal mine employment. Dr. Tuteur is board-certified in internal medicine and pulmonary medicine.

During an April 4, 2000 deposition, Dr. Paul Wheeler, a board-certified radiologist and B-reader, discussed his interpretations of the claimant's chest x-rays and computer tomography scan. (EX 6). When asked whether he saw anything that would suggest small opacities which could be related to the claimant's coal mine employment, Dr. Wheeler responded:

> I didn't see any nodules. What I am looking for in silicosis is nodular infiltrates, symmetrical birdshot or buckshot nodules in the central portion mid and upper lung zones. One of the hallmarks of any pneumoconiosis is symmetry. And for silicosis and coal worker's pneumoconiosis it's nodules symmetrically in the central portion mid and upper lungs. In far advanced cases, it can extend to the periphery and even to the apices and pleura, but it's always going to predominate centrally near the hila. And in this case, the hila were elevated. And that's quite characteristic of tuberculosis, to scar the upper portions of the upper lobes and pull the hila up, wheras, silicosis usually just causes nodules central portion mid and upper lungs. It doesn't pull the hila up. It can involve the hila, but doesn't pull them up.

In discussing his interpretation of a February 12, 1999 x-ray film, Dr. Wheeler stated:

> [T]here were coarse and focal infiltrates or fibrosis in the upper lobes and lower apices, again, compatible with tuberculosis, unknown activity. I also felt there were some smaller opacities. The primary one I thought was the U or coarse, blotchy, irregular opacity. There also could have been a few R nodules. But those R nodules are very likely granulomata. So, I put it in as a possibility. And it was in the mid and upper lung zones. And I considered that tuberculosis was much less likely to do this–that silicosis and coal workers' pneumoconiosis were much less likely to do this than granulomatous disease. For that reason, I put those opacities down as 0/1, meaning there are possibly some present, but the major disease process in these upper lobes is tuberculosis or some other granulomatous disease.

The physician further stated the February 12, 1999 x-ray contained:

> [S]ome pleural fibrosis near the scapulae. And that's quite typical of tuberculosis. Pneumoconiosis is unlikely because the pattern is coarse, involves the pleura and the lower apices.

Dr. Wheeler also discussed his interpretations of July 28, 1999 chest x-rays and computer tomography scans. The physician testified the computer tomography scan revealed what he thought were conglomerate masses of tuberculosis in the subapical portions of the upper lobes and lower apices. The physician explained "the strike zone for silicosis is near the hila, central portion mid and upper lungs, but when you get to the apices and subapical areas, it's outside the strike zone in my opinion, my experience." The physician also stated the computer tomography scan revealed arteriosclerosis of the coronaries, which Dr. Wheeler thought was "unusual" in an individual so young. Dr. Wheeler further testified the computer tomography scan showed evidence of emphysema, "with small bullous blebs in the upper lobes and apices,...quite typical of cigarette smoking."

When discussing the July 28, 1999 chest x-ray, Dr. Wheeler stated:

> There are moderate, coarse nodular infiltrates or fibrosis in the upper lobes and lower apices, extending to the pleural, very similar description. And on the chest x-ray, I reported a three to four centimeter mass in the subapical portion of both upper lobes compatible with conglomerate tuberculosis. Now, I may have been working from what I knew was on the CT scan, but usually if I don't see it on the chest x-ray, I will simply report an infiltrate even though I know there is a mass on the CT scan and I will say there is CT scan evidence of a mass. But in this case, the mass I believe was visible on the chest x-rays in both upper lobes three to four centimeters in diameter.

The physician further testified he did not see the masses on the August 1998 and February 1999 films. He attributed his failure to note the masses on the earlier films to the fact that he read the earlier films on two separate occasions and that he interpreted the July 28, 1999 x-ray and computer tomography scan on the same day.

When asked to explain why he thought the masses in the miner's lungs were masses related to granulomatous disease rather than large opacities, Dr. Wheeler responded:

> I like to see large opacities develop from nodular infiltrates, true nodular infiltrates, ones that are primarily small nodules, anywhere from less than a millimeter up to a centimeter in diameter. Those weren't the primary elements within the infiltrates I saw in these chest x-rays. In other words, I wasn't seeing a predominantly nodular infiltrate in the central portion mid and upper lungs followed by the development of a mass. What I found were coarse infiltrates on chest x-rays. And when we had the CT scan, the CT

> scan also showed that there were infiltrates in areas of – focal infiltrates and coarse fibrosis, not predominantly small, rounded nodules. There were a few scattered nodules. And those nodules were in the periphery of the mid and lower lungs. They weren't in the central portion of the mid and upper lungs. So, without the building blocks, so to speak, the bricks from which to build a large opacity in the central portion mid and upper lungs, I couldn't make a diagnosis of conglomerate–of large opacities from silicosis or coal workers' pneumoconiosis.
>
> Dr. Wheeler explained that:
>
> Nodules are nodules. And you can have them from metastatic disease, from granulomatous disease and from silicosis and coal workers' pneumoconiosis....So, what we are seeing here are really coarse, irregular infiltrates with a few nodules, not lots of nodules and a few infiltrates. So, my view is that this is granulomatous disease until proven otherwise.

Dr. Wheeler testified that for his purposes, granulomatous disease means "tuberculosis, primarily." When asked to discuss the profusion of the infiltrates noted on the miner's chest x-ray, Dr. Wheeler responded:

> [u]sually with coal workers' pneumoconiosis, to get a large opacity, you have to have a significant number of nodules. The nodules I am seeing here are quite sparse, and they are peripheral and not central. They are sort of smallish nodules. Usually to form a large opacity, you have to have QR, small rounded opacities which can be up to a centimeter in diameter. And that's not what we're seeing here.
>
> Dr. Wheeler testified that Mr. Fife suffers from granulomatous disease. The physician stated:
>
> [t]here may be a few nodules from silicosis, and I indicated that, or coal workers' pneumoconiosis, on the forms, but in my opinion this is granulomatous disease of some form. I am not absolutely certain it's tuberculosis, although the location is excellent for tuberculosis.

E. Computer Tomography Scan Evidence

Drs. Scott and Wheeler interpreted a July 28, 1999 computer tomography scan of Mr. Fife's chest. Dr. Wheeler rendered the following interpretation on August 11, 1999:

> Good quality exam with two different lung settings and scan thickness but no mediastinal settings: arteriosclerosis coronaries/check for angina pectoris because coronary artery disease can lead to sudden death. Advanced conglomerate tuber-

culosis with masses in subapical portion upper lobes and lower apices containing tiny calcified granulomata and adjacent focal infiltrates or coarse fibrosis extending to lateral pleural fibrosis indicating at least partial healing. Few scattered nodules in periphery mid and lower lungs compatible with granulomata and at least one calcified granuloma in left posterolateral pleura. Minimal emphysema with several small bullous blebs in upper lobes and apices and few in both lower lobes. Tuberculosis explains all the lung findings in this case except emphysema and the man is quite young.

Dr. Scott interpreted the computer tomography scan on August 18, 1999 and found:

[b]ilateral nodular apical infiltrates and/or scarring. Multiple calcified granulomata are present within the larger masses. There is associated pleural thickening. The changes are compatible with tuberculosis of unknown activity, but partially healed as evidenced by calcified granulomata. There is no background of small rounded opacities to suggest that masses could be rounded opacities of pneumoconiosis. A few scattered blebs and bullae are present in the lungs.

DISCUSSION AND APPLICABLE LAW

Pneumoconiosis

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. The United States Court of Appeals for the Fourth Circuit has recently held that an administrative law judge must weigh all of the evidence together under section 718.202(a) to determine whether a miner suffers from coal workers' pneumoconiosis. *Island Creek Coal Co. v. Compton*, ___ F.3d ___, 2000 WL 524798 (4th Cir. 2000). Therefore, I will first evaluate the evidence under each subsection to determine whether the evidence weighs in favor or against a finding of pneumoconiosis. I then will weigh all of the probative evidence together to determine whether Mr. Fife has proven by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis.

Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. As noted above, I may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 BLR 1-6 (1988); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc). Drs. Scott and Wheeler, two dually-qualified physicians, read an August 27, 1998 x-ray as negative for pneumoconiosis. Dr. Sargent, a dually-qualified physician,[2] and Dr. Forehand, a B-reader, interpreted a February 12, 1999 x-ray as positive for category 1/1 pneumoconiosis. Drs. Scott and Wheeler classified the same x-ray as category 0/1.

[2] A dually qualified physician is a physician who is both a B-reader and a Board-certified radiologist.

Dr. Scott thought the changes on the February 12, 1999 x-ray were "compatible with tuberculosis" while Dr. Wheeler stated the changes were "most likely untreated tuberculosis." Dr. Wheeler also thought "it would be unusual for a man [as young as Mr. Fife] to have advanced pneumoconiosis without overwhelming unprotected dust exposure." Dr. Dahhan, a B-reader, read the miner's July 28, 1999, chest x-ray as positive for category 1/1 pneumoconiosis. When interpreting the same x-ray, Dr. Scott again thought the changes were "compatible with tuberculosis." Dr. Wheeler classified the x-ray as category 0/1 while acknowledging that "silicosis and coal workers' pneumoconiosis could account for some nodules," but thought that "tuberculosis best explain[ed] all [the] findings." The claimant's most recent chest x-ray, which was taken on December 21, 1999, was interpreted as positive by Dr. Alexander, who is a board-certified radiologist and B-reader. Drs. Wheeler and Scott classified the x-ray as a category 0/1. Dr. Scott stated he could not rule out minimal silicosis/coal workers' pneumoconiosis, but opined the changes were "probably" due to tuberculosis. Dr. Wheeler thought the changes were "compatible with conglomerate tuberculosis," and thought the masses in the upper lobes were "unlikely" large opacities "because there [was] apical and pleural disease and the miner [was] quite young." Dr. Wheeler noted he thought most large opacities occur in unprotected drillers from World War II.

I accord little evidentiary weight to the x-ray readings of Drs. Wheeler and Scott because the physicians' x-ray interpretations are equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995). Neither Dr. Wheeler nor Dr. Scott were able to offer an unequivocal explanation for the abnormalities on the claimant's chest x-rays. The physicians simply opined the x-ray changes were "compatible with, " "best explain[ed] by," "most likely," and "probably" tuberculosis. The use of such equivocal words and phrases reflects uncertainty on behalf of Drs. Wheeler and Scott. Furthermore, not only were the physicians unable to offer a clear explanation for the abnormalities revealed by Mr. Fife's chest x-rays, Drs. Wheeler and Scott also were unable to unequivocally conclude that Mr. Fife does not suffer from pneumoconiosis. When interpreting the February 12, 1999 x-ray film, Dr. Wheeler stated it is "unusual" for a man of Mr. Fife's age to suffer from advanced pneumoconiosis "without overwhelming unprotected dust exposure." Dr. Wheeler also acknowledged that "pneumoconiosis/silicosis could account for some [of the] nodules" revealed by the miner's July 28, 1999 x-ray. Dr. Scott also stated he could not rule out minimal silicosis/coal worker's pneumoconiosis when he read the claimant's December 21, 1999 x-ray.

In contrast, I accord greater evidentiary weight to the x-ray readings of Drs. Alexander, Dahhan, Forehand, and Sargent. Drs. Sargent and Alexander are board-certified radiologists and B-readers. Drs. Forehand and Dahhan are B-readers. These four physicians have clearly and unequivocally interpreted the claimant's 1999 chest x-rays as positive for pneumoconiosis. Consequently, I find the x-ray evidence weighs in favor of at least a finding of simple pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. As discussed above, Drs. Wheeler and Scott offered equivocal explanations of the abnormalities on the miner's chest x-rays. Drs. Forehand, a B-reader, and Dr. Alexander, a dually-qualified physician, read the claimant's x-rays as positive for pneumoconiosis and noted the presence of large opacities. Dr. Sargent read the claimant's February 12, 1999 chest x-ray as positive for pneumoconiosis and designated size A large opacities, but the physician indicated he was uncertain about whether the x-ray findings indicated early large opacities, tuberculosis, or granulomatous disease. Therefore, I find Dr. Sargent's interpretation of the February 12, 1999 x-ray film has little probative value because it is equivocal as to the existence of complicated pneumoconiosis. *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988).

As part of a July 28, 1999, pulmonary evaluation, Dr. Dahhan, a B-reader, interpreted a chest x-ray as positive for category 1/1 pneumoconiosis and noted size A large opacities. In a July 28, 1999 examination report, the physician opined there was no evidence of pneumoconiosis and attributed the abnormalities to granulomatous disease. During an April 2000 deposition, Dr. Dahhan explained the designation of size A large opacities by stating he saw a "large shadow" on the x-ray film which he thought could have been consistent with a size A large opacity. After reviewing a computer tomography scan reading by a physician other than himself which Dr. Dahhan thought was not indicative of a large opacity, Dr. Dahhan concluded Mr. Fife does not suffer from pneumoconiosis. When asked to explain the abnormalities on the chest x-ray, Dr. Dahhan stated the abnormalities were "probably due to old granulomatous disease, most likely tuberculosis."

Dr. Dahhan did not identify the computer tomography scan upon which he relied to retract his finding of size A large opacities; however, there are only two computer tomography scan interpretations in the record. Drs. Wheeler and Scott interpreted a July 28, 1999 computer tomography scan of the claimant's chest. In his computer tomography scan report, Dr. Wheeler noted the presence of "advanced conglomerate tuberculosis" and opined that "tuberculosis explain[ed] all of the lung findings...except emphysema." Dr. Scott noted the changes were "compatible with tuberculosis of unknown activity." The physician also stated there was "no background of small rounded opacities to suggest the masses could be rounded opacities of pneumoconiosis."

During an April 4, 2000 deposition, Dr. Wheeler discussed his interpretations of the miner's computer tomography scan and chest x-rays. The physician testified that his opinion is that the claimant suffers from some form of granulomatous disease until it is proven otherwise.

In a letter dated February 9, 2000, Dr. Sutherland, a physician who had treated the claimant for approximately seven years, opined the claimant suffers from a significant, irreversible, obstructive and restrictive lung disease. I find such a statement, even if made by the claimant's treating physician,

insufficient to constitute a diagnosis of complicated pneumoconiosis. Dr. Sutherland also stated Mr. Fife "was evaluated for tuberculosis and coccidial mycosis," but no evidence of either disease was found. Although Dr. Sutherland's opinion provides an insufficient basis for a finding of complicated pneumoconiosis, his statements regarding Mr. Fife's tuberculosis evaluation are entitled to great weight. Dr. Sutherland is the only physician of record who has evaluated the claimant for tuberculosis. Because Dr. Sutherland had been the claimant's treating physician for approximately seven years, and because Dr. Sutherland is the only physician of record who has evaluated the claimant for tuberculosis, I accord great weight
to Dr. Sutherland's opinion that Mr. Fife's evaluation revealed no evidence of tuberculosis.

I accord little evidentiary weight to the opinions of Drs. Scott, Wheeler, and Dahhan because the record does not indicate the physicians considered Mr. Fife's negative tuberculosis evaluation before they rendered their opinions. The physicians's failure to consider the negative tuberculosis evaluation tends to undermine the reliability of their opinions that claimant suffers from tuberculosis. *Hutchens v. Director, OWCP*, 8 BLR 1-16 (1985). The x-ray readings of Drs. Wheeler and Scott repeatedly reference abnormalities which the physicians equivocally attributed to tuberculosis. Furthermore, Dr. Wheeler testified at his deposition that for his purposes, granulomatous disease means "tuberculosis primarily." The physician further testified that his opinion is that Mr. Fife suffers from "granulomatous disease, until proven otherwise." Because the physician stated he used the phrase granulomatous disease to refer primarily to tuberculosis and because Mr. Fife's tuberculosis evaluation revealed no evidence of the disease, I accord little weight to Dr. Wheeler's opinion that Mr. Fife suffers from granulomatous disease until proven otherwise.

Moreover, I accord little evidentiary weight to the July 28, 1999 computer tomography scan interpretations of Drs. Wheeler and Scott. Dr. Wheeler thought tuberculosis explained all of the miner's lung findings except emphysema. Dr. Scott opined the changes in the miner's lungs were compatible with tuberculosis. Neither interpretation takes into consideration the fact that the claimant was evaluated for tuberculosis by his treating physician and no evidence of the disease was found. Consequently, I find the computer tomography scan readings of Dr. Wheeler and Dr. Scott are of little probative value.

There are two reasons why I give little evidentiary weight to Dr. Dahhan's opinion. First, as with Drs. Wheeler and Scott, Dr. Dahhan equivocally attributed the abnormalities on the claimant's chest x-ray to granulomatous disease, particularly tuberculosis. Not only did the physi-cian offer an equivocal explanation for the claimant's lung abnormalities, but the physician also failed to consider that Mr. Fife had been evaluated for tuberculosis and that no evidence of the disease with which he equivocally diagnosed the claimant was found. Although Dr. Dahhan's failure to consider the claimant's negative tuberculosis evaluation provides a suffi-cient basis for according his opinion less evidentiary weight, I also note an additional factor which decreases the probative value of Dr. Dahhan's opinion. Dr. Dahhan's July 28, 1999 x-ray report is inconsistent with his narrative opinions and the physician failed to adequately explain the inconsistency. *Hopton v. U.S. Steel Corp.*, 7 BLR 1-12

(1984); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 BLR 1-799 (1984). Dr. Dahhan's July 28, 1999 x-ray report denotes category 1/1 parenchymal abnormalities consistent with pneumoconiosis and size A large opacities. Dr. Dahhan testified the July 28, 1999 x-ray contained a "large shadow" Dr. Dahhan thought "could be consistent with a size A large opacity." The physician further testified that he changed his mind about the presence of a large opacity after reviewing a computer tomography scan reading by a physician whom Dr. Dahhan thought was "experienced" in radiology. Dr. Dahhan stated that he concluded the physician's computer tomography scan reading was not indicative of a large opacity, and thus retracted his diagnosis of complicated pneumoconiosis on the x-ray report. I find Dr. Dahhan's explanation of the inconsistency between his x-ray reading and his narrative opinions inadequate because Dr. Dahhan did not independently review the computer tomography scan. He simply relied upon the reading of another physician. Moreover, Dr. Dahhan failed to relate the findings upon which he relied in the physician's computer tomography scan reading and failed to explain why those findings were not indicative of a large opacity. Thus, to the extent Dr. Dahhan failed to adequately explain why he changed his mind about the presence of a large opacity, I find both his x-ray report and his narrative opinions are entitled little evidentiary weight.

Dr. Tuteur, another highly-qualified physician of record, rendered a consultative medical opinion on October 5, 1999. Dr. Tuteur noted Mr. Fife does not have a history of being diagnosed with tuberculosis. The physician opined the claimant does not suffer from "clinically significant or physiologically significant coal workers' pneumoconiosis." Dr. Tuteur stated "the consensus, based on both standard chest radiographs and a computer tomography scan of the thorax, suggest the absence of coal workers' pneumoconiosis and the presence of the tissue reaction in response to infection." Thus, Dr. Tuteur relied in the computer tomography scan and x-ray readings of Drs. Wheeler and Scott and did not independently evaluate the July 28, 1999 computer tomography scan or the miner's chest x-rays. Dr. Tuteur diagnosed the miner with early chronic obstructive pulmonary disease caused by cigarette smoking. The physician also stated the emphysematous changes noted on the claimant's computer tomography scan and suspected on some of the claimant's chest x-rays were caused by a cigarette-smoke induced condition. Although Dr. Tuteur considered the claimant has no history of being diagnosed with tuberculosis, I accord his opinion less weight than the opinion of Dr. Forehand because Dr. Tuteur offered only a vague explanation for the abnormalities on the claimant's chest x-ray. Dr. Tuteur stated the "consensus" based on the x-ray and computer tomography scan readings "suggest[s] the absence of pneumoconiosis and the presence of the tissue response to an infection." The physician did not discuss how the miner's tissue had responded and did not explain why the abnormalities were consistent with an infection as opposed to a large opacity. Thus, to the extent Dr. Tuteur only vaguely explained the abnormality on the miner's chest x-ray, I accord his opinion less weight than the clear and unequivocal medical opinions of record. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995).

In contrast, I accord great weight to Dr. Forehand's opinion that the claimant suffers from complicated pneumoconiosis because the physician's opinion is supported by specific physical examination findings, the miner's employment and smoking histories, and a chest x-ray. I also accord

greater weight to the opinion of Dr. Forehand than to the opinion of Dr. Tuteur because Dr. Forehand examined the claimant and has first-hand knowledge of the claimant's condition. *Onderko v. Director, OWCP*, 14 BLR 1-2 (1989). Dr. Forehand diagnosed Mr. Fife with complicated pneumoconiosis. The physician also acknowledged the claimant "should have a tuberculin skin test to rule out tuberculosis as an additional diagnosis." Thus, Dr. Forehand's diagnosis of complicated pneumoconiosis, unlike the opinions of Drs. Wheeler, Scott, and Dahhan, is not affected by Dr. Sutherland's subsequent evaluation of the miner for tuberculosis which revealed no evidence of the disease.

In summary, Drs. Alexander, Dahhan, Forehand, and Sargent have acknowledged the presence of a large abnormality on the claimant's chest x-rays.[3] Drs. Wheeler and Scott have also acknowledged the presence of a large abnormality in the miner's lungs, but they have only equivocally explained its presence. After reviewing all of the evidence of record which is relevant to the existence or nonexistence of complicated pneumoconiosis, I find that the narrative medical opinion of Drs. Forehand and Sutherland and the x-ray readings of Drs. Forehand and Alexander are entitled greater weight than the equivocal x-ray readings of Drs. Wheeler, Scott, and Sargent, the equivocal and inconsistent medical opinion of Dr. Dahhan and the vague opinion of Dr. Tuteur, a physician who has no first-hand knowledge of Mr. Fife's condition. Because I accord greater weight to the opinions and x-ray readings of Drs. Forehand and Alexander than to the opinions and x-ray readings of Drs. Sargent, Wheeler, Scott, Dahhan, and Tuteur, I find Mr. Fife has established the existence of complicated pneumoconiosis by a preponderance of the evidence.

Etiology of Pneumoconiosis

Because the claimant has established over ten years of qualifying coal mine employment, he is entitled to a rebuttable presumption that his complicated pneumoconiosis arose out of his coal mine employment. 20 C.F.R. § 718.203(b). The employer has proffered no evidence to rebut this presumption. Therefore, I find Mr. Fife's complicated pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a).

Total Disability

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204 (b)(2). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Because Mr. Fife has established that he suffers from

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[3]Drs. Alexander and Forehand have opined the abnormality represents complicated pneumoconiosis. Dr. Sargent was uncertain as to whether the abnormality was complicated pneumoconiosis, tuberculosis, or some other form of granulomatous disease. Dr. Dahhan indicated the presence of complicated pneumoconiosis on his x-ray report, but later attributed the abnormality to granulomatous disease, particularly tuberculosis.

complicated pneumoconiosis, Mr. Fife is irrebuttably presumed totally disabled due to pneumoconiosis. 20 C.F.R. § 718.304. Thus, Mr. Fife has established entitlement to benefits under the Act.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where a miner establishes that he has complicated pneumoconiosis, the onset date is the month during which complicated pneumoconiosis was first diagnosed. *Truitt v. North American Coal Corp.*, 2 BLR 1-199, 1-203 to 1-204 (1979). Dr. Forehand first diagnosed the claimant with complicated pneumoconiosis during February 1999. Therefore, the claimant shall receive benefits commencing February 1999.

Lay Representative's Fee

A lay representative's fee for services rendered to the claimant is not awarded herein because no application for fees has been made by the claimant's representative. The Act prohibits the charging of a fee in the absence of an approved application. The claimant's representative is hereby granted thirty (30) days to submit an application for fees which conforms to the requirements of 20 C.F.R. § 725.365 and § 725.366 of the regulations. A Service Sheet, indicating that service has been made to all parties, including the claimant, must accompany the application for fees. The parties have fifteen (15) days following receipt of the application to file any objections they may have. Failure to file objections within the fifteen day period will serve as notice that the parties agree that the petition is fair and reasonable and that the parties have no objections to said petition for fees. Any lay representative's fee awarded will be the responsibility of the claimant and cannot be made a lien against benefits awarded. *See Harrison v. Liberty Mutual Insurance Co.*, 3 BLR 1-596, 1-597 (1981); 20 C.F.R. § 725.365.

ORDER

The employer, YOGI MINING COMPANY, INC., is hereby ORDERED to pay the following:

1. To claimant, TERRY FIFE, all benefits to which he is entitled under the Act, augmented by his reason of his two dependents, commencing February 1999;

2. To claimant, all medical and hospitalization benefits to which he is entitled, commencing February 1999;

3. To the Secretary of Labor, reimbursement for any payment the Secretary has made to claimant under the Act. The employer may reduce such amounts, as appropriate, from the amounts the employer is ordered to pay under paragraph

1 above; and,

4. To the Secretary of Labor or to claimant, as appropriate, interest computed in accordance with the provisions of the Act or regulations.

JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision by filing a notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, - Washington, D.C. 20210.